CHAPTER 33-03-15
HOSPICE PROGRAMS

33-03-15-01. General provisions.

1. A new hospice program is subject to certificate of need review pursuant to North Dakota Century Code chapter 23-17.2.

2. The department must be notified in writing when a change of ownership, operation, location, or when discontinued or addition of a new service in a hospice program is contemplated.

3. The hospice program shall provide physician services, nursing services, medical social services, counseling services, bereavement services, volunteer services, home health aide and homemaker services, and short-term inpatient care. Two of these service must be provided directly. Direct services are those services provided by hospice program employees or volunteers. All other services may be provided through written contract or written agreement.

4. Nursing services and physician services shall be routinely available twenty-four hours a day seven days a week, as may be required in accordance with the hospice program service plan.

5. The home care component must be the primary form of care, and must be available on a part-time, intermittent, regularly scheduled basis, and on an on-call, around-the-clock basis according to patient and family needs.

6. Short-term general inpatient care must be provided only in licensed hospitals or licensed skilled nursing facilities. If feasible, inpatient

care must closely approximate a homelike environment and provide overnight family visitation within the facility.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-02. Governing body and management.

1. A hospice program must have a clearly defined, organized governing body that must assume full legal responsibility for the overall conduct and operation of the hospice program including quality of care and services.

2. The governing body shall adopt bylaws which include at least the following:

   a. The purpose of the hospice program.

   b. The powers and duties of the officers and committees of the governing body.

   c. The qualifications, methods of selection, and terms of office of members and chairman of committees.

   d. A mechanism for approval of the appointment to the medical staff, if applicable.

   e. Specifications of the frequency of governing body meetings and attendance requirements.

   f. A provision for the taking of sufficient minutes of its meetings to record the business conducted and for making them available to all members.

3. There must be an organizational chart, description of services offered, and channels of authority for responsibility for care provided to patients and their families.

4. There must be policies and procedures for each department or service offered, which must be reviewed annually by the governing body, or appropriate administrative representative.

   a. Policies and procedures must be dated and signed to indicate the time of the most recent review.

   b. All pen and pencil changes of policies and procedures must be dated with the date the change or revision was made and initialed by the department head.

5. When the hospice has services, including inpatient care, provided for under arrangement, there must be a current written agreement which must be signed and dated by the administrator of the hospice program, and the duly authorized official of the agency providing the service or resource. The agreement must clearly delineate the responsibilities of the parties involved and must include no less than the following:

    a. Identification of services to be provided.

    b. A stipulation that services provided are consistent with the hospice service plan of care.

    c. The manner in which the contracted services are coordinated, supervised, and evaluated.

    d. A statement that the hospice program retains the responsibility for planning and coordinating services and care on behalf of the patient and family.

    e. Procedures for submitting clinical and progress notes when applicable.

    f. Assurance that personnel and services contracted for meet the requirements specified herein pertaining to personnel and services, including licensure, personnel qualifications, and attendance at care conferences.

    g. Reimbursement mechanism, charges, and terms for the renewal or termination of the agreement.

6. The governing body shall approve an annual operating budget and capital expenditure plan.

7. The governing body or its appropriate administrative representative shall appoint a member of the hospice program team who is responsible for providing for coordination and administration of hospice program service plan for patients and families. The person appointed shall:

    a. Develop, implement, and annually evaluate the policies and procedures for the total hospice program operation.

    b. Provide a formal budget that reflects the organization of the hospice program.

    c. Provide a designation, in writing, of a qualified individual to act in the administrator’s absence.

d. Act as a liaison between the governing body, medical staff, and other hospice program staff.

e. Implement personnel policies and practice with orientation of all new employees, maintenance of complete personnel records for each employee, verification of applicable current licensure or registration of personnel, performance evaluation based on a job description, and current health requirements.

f. Provide an ongoing program of training including orientation and continuing education for all employees. Records of inservice training must be maintained which list the content of and attendance at staff development programs.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-03. Physician services.

1. Physician services must be provided by a physician licensed pursuant to North Dakota Century Code chapter 43-17 to meet the general needs of patients for management of the terminal illness and related conditions through palliative and supportive care and in accordance with hospice program policies.

2. The hospice program must have a medical director who is a physician licensed pursuant to North Dakota Century Code chapter 43-17.

3. The medical director has overall responsibility for medical policy in relation to the care and treatment of hospice program patients and their families provided by the hospice program care team.

4. Duties of the medical director include, but are not limited to:

   a. Consulting and cooperating with the hospice program patient's attending physician.

   b. Participating in the development of the hospice program service plan.

   c. Serving as a liaison between the attending physician and the interdisciplinary team.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-04. Nursing services.

1. The hospice program must provide the services of a registered nurse, licensed pursuant to North Dakota Century Code chapter 43-12.1, to organize, supervise, and coordinate the palliative and supportive care for patients and families provided by the hospice program care team.

2. The nurse supervisor is responsible for the development, maintenance, and revision of nursing care policy and procedure manuals, written job descriptions for each level of personnel, methods of coordination of nursing service with other services, and shall recommend the number and levels of nursing personnel to be employed.

3. The nursing services supervisor shall designate a qualified registered nurse to act in the supervisor's absence.

4. Nursing services must be directed and staffed to assure the nursing needs of patients are met.

5. There must be staff development programs and educational opportunities for nursing personnel which include orientation and inservice education.

    a. There must be documentation maintained of the staff development program which includes content of program, name of instructor, name of those in attendance, length of program, and date of presentation.

    b. Records must validate that initial orientation, including appropriate training to the tasks which personnel are expected to perform, and continual training is evident.

6. The hospice program must develop and maintain written policies and procedures for the administration and provision of pharmaceutical services consistent with the drug therapy needs of the patient. Policies and procedures must include, but not be limited to: the administration of treatment modalities, including intravenous procedures, chemotherapy, parenteral feedings, and injections; prescribing, preparing, administering, and recording of all drugs and biologicals; recording and reporting medication errors and adverse drug reactions.

    a. The hospice program must have a policy for the disposal of controlled drugs maintained in the patient's home when these drugs are no longer needed by the patient.

    b. Medications administered to patients must be ordered in writing, and the orders shall be authenticated by the person legally authorized to prescribe the medication.

c. A verbal medication order may be given to a licensed nurse, physician, or registered pharmacist. The hospice program shall initiate action to obtain the physician's signature for verbal orders within forty-eight hours.

d. Drugs and biologicals must be administered by the following:

(1) A licensed nurse or physician.

(2) The patient, a family member, or other caregiver, as specified in the patient's hospice program service plan.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-05. Medical social services.

1. Medical social services must be provided by a qualified social worker licensed under North Dakota Century Code chapter 43-41.

2. Policies and procedures pertaining to social services must be provided, approved, and reviewed annually.

3. Records of pertinent social data about personal and family problems medically related to the patient's illness and care and action taken to meet the patient and family needs must be maintained in the patient's medical record.

4. Social services must be provided in accordance with the plan of care. The social worker shall assist and work with the hospice program care team in identifying significant social and emotional factors related to care. The scope of social work services must include, as a minimum:

a. Assisting in preadmission and discharge planning.

b. Conducting an assessment to determine the emotional and social needs of the patient and family.

c. Counseling the patient and family on an individual and group basis.

d. Identifying, utilizing, and working to develop appropriate community resources.

e. Maintaining adequate records relating to social work services which must be included in the patient's medical record.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-06. Counseling services.

1. Spiritual counseling services must be available, upon request, to the patient and family. The hospice program may not impose the dictates of any value or belief system on hospice program patients or their families.

2. Dietary counseling services must be available to the patient and family, and must be provided by a dietitian licensed under North Dakota Century Code chapter 43-44.

3. Spiritual, dietary, and other counseling services provided must be documented in the patient and family record.

4. All counseling services must be provided in accordance with written policies and procedures governing the delivery and documenting of such services.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-07. Bereavement services.

1. The hospice program must provide bereavement counseling and services to the patient's immediate family or primary caregiver. Bereavement services must be available for at least one year following the death of the patient.

2. Such services must be supervised by an individual qualified by training and experience for the development, implementation, and assessment of a hospice program service plan to meet the needs of the bereaved.

3. The individual supervising bereavement counseling may be a registered nurse, counselor, social worker, or other persons with documented evidence of training and experience in dealing with bereavement.

4. The hospice program must adopt written policies and procedures relating to this service.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-08. Volunteer services.

1. The hospice program must provide for appropriate orientation and training that is consistent with acceptable standards of hospice program practice. There must be a written orientation checklist that identifies the tasks the individual is expected to perform. The training and orientation program must include, as a minimum:

   a. Hospice program goals, services, and philosophy.

   b. Confidentiality and protection of patient and family rights.

   c. Family dynamics, coping mechanism, and psychological issues surrounding terminal illness, death, and bereavement.

   d. Procedures to be followed in an emergency and following the death of a patient.

   e. Guidance related specifically to individual responsibilities.

2. The hospice program must establish a mechanism to assure volunteers are effectively performing the duties and responsibilities assigned.

3. A hospice volunteer may provide direct patient care only when the following provisions are met:

   a. Tasks and responsibilities are specified in writing and do not exceed the individual's capability.

   b. Care is consistent with the hospice service plan.

   c. The professional volunteer must be appropriately licensed or registered, if required.

   d. Services rendered must be recorded in the patient's record.

   e. The volunteer must have a clear understanding of the volunteer's duties and responsibilities.

   f. Volunteers must be informed to whom they report and whom to contact if assistance is needed in carrying out their responsibilities.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-09. Home health aide services.

1. The hospice program must provide homemaker and home health aide services as prescribed by the patient and family plan of care and consistent with policies of the hospice program.

2. The homemaker and home health aide may be assigned responsibilities and duties only after satisfactorily completing an organized education and training program consistent with and applicable to the hospice program.

3. The homemaker and home health aide shall provide care and other related services upon written instruction for patient care prepared by a registered nurse or therapist as appropriate. Duties of the home health aide include:

   a. The performance of simple procedures as an extension of therapy services.

   b. Personal care.

   c. Ambulation and exercise.

   d. Household services essential to health care at home.

   e. Reporting changes in the patient's condition and needs.

   f. Completing appropriate records.

4. A registered nurse must visit the homesite at least every two weeks when aide services are provided. Documentation in the patient's medical record must include an assessment of the aide service.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-10. Interdisciplinary team services.

1. The hospice program must designate interdisciplinary groups composed of individuals who provide or supervise the care and services offered by the hospice program.

2. The following individuals must be members of the interdisciplinary group or hospice program care team:

   a. Patient and family.

   b. Physician including the medical director and attending physician.

c. Registered nurse.

d. Medical social worker.

e. Trained volunteers.

f. Providers of special services including a spiritual counselor, a registered pharmacist, a registered dietitian, or professional in the field of mental health may be included in the hospice care team as determined appropriate by the hospice program.

3. Members of the hospice care team must have access to emotional support, as necessary, concerning job-related issues.

4. The interdisciplinary group is responsible to:

a. Participate in the establishment of the hospice service plan.

b. Provide for supervision of hospice care and services.

c. Review and update of the hospice service plan for each individual receiving hospice care.

d. Establish policies and procedures governing the day-to-day provision of hospice care and services.

e. Coordinate home and inpatient service.

5. The hospice program must identify a qualified member of the hospice care team who will be responsible for coordination and administration of the hospice service plan for patient and family. This person shall assure that adequate exchange of information, communication, and interaction occurs between all disciplines providing care.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-11. Admission criteria.

1. Admission criteria must be clearly defined in the hospice program policies. Decisions regarding admission must be made by the hospice care team.

2. Admission to the hospice program must be by request of the patient. If the attending physician certifies that the patient is unable to request admission, a family member may request admission on the patient's behalf.

3. Any request to the hospice program must include written evidence of an informed consent signed by the person making the request. The informed consent must specify the type of care and services provided as part of hospice care and must be understandable to the person signing the consent.

4. If the hospice program requires a primary caregiver for each admission, this must be specified in the admission criteria and discussed with the patient and family during the patient's initial assessment.

5. A hospice program may not deny acceptance to any patient and family for services of the hospice on grounds of race, color, national origin, age, sex, religion, or ethnic affiliation.

6. At the time of admission to the hospice program, the hospice program must obtain documentation from the attending physician that the patient is terminally ill with an anticipated life expectancy of six months or less.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-12. Hospice service plan of care.

1. After an initial assessment of patient and family needs, a written plan of care must be established by the hospice care team for each patient and family admitted to the hospice program.

   a. At least a registered nurse or physician shall conduct an initial assessment of each patient and shall meet with one hospice care team member to develop the initial plan of care prior to admission.

   b. Within seven days following admission of each patient and family, the hospice care team members shall meet to develop a comprehensive hospice service plan of care.

   c. The hospice service plan of care must be developed with the participation of the patient and family and may include only those services which are acceptable to the patient and family. The family must be involved whenever possible in the implementation and continuous assessment of the hospice service plan of care.

2. The hospice service plan of care must include at least the following:

   a. Patient diagnosis.

   b. Complete assessment of patient and family needs.

c. Appraisal of, and need for, symptom control.

d. Identification of problems and goals and the types of services required to meet the patient and family goals.

e. Frequency of the services, medication, treatments needed to meet patient and family needs and the discipline involved in the delivery of care.

3. There must be written policies and procedures relating to the development, review, and revision of the hospice service plan in the home care and inpatient services. The plan of care must be reviewed, updated, and documented as needed, but at least biweekly, by the hospice care team.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-13. Medical records.

1. The hospice program must keep accurate, current, and confidential records of all hospice patients and their families. The hospice program must safeguard the medical record against loss, destruction, and unauthorized use. Overall responsibility for medical records must be assigned to an employee of the hospice program.

2. The medical record must be complete, and documented promptly, accurately, and legibly.

3. Each medical record must contain sufficient information on all services provided, whether furnished directly or under arrangement by the hospice program, and entries must be signed with the legally acceptable signature by the person making the entry. Each patient and family medical record must contain, but is not limited to, the following:

a. Complete identification of each patient, including information on the patient's next of kin and responsible person or agency.

b. The initial and subsequent assessments by each discipline involved with the patient and family.

c. A medical history obtained prior to the development of a hospice care plan.

d. A current hospice care team plan.

e. Complete documentation of all home visits and services rendered if the service is provided directly.

f. If home care is not provided directly, provision must be made for the hospice program to obtain, as a minimum, a summary of services provided that reflect pertinent information relevant to the patient's and family's care.

g. Consent and authorization forms.

h. Patient diagnosis and prognosis certified by the attending physician.

i. Legible therapeutic orders authenticated by the attending physician. Action must be initiated by the hospice program to obtain the physician's signature for verbal orders within forty-eight hours.

j. At the time of discharge or transfer, the hospice must provide those responsible for the patient's care with an appropriate summary of information, including the hospice service plan, about the patient to ensure the optimal continuity of care.

k. Bereavement care plan and progress notes including bereavement assessment and followup.

4. Pertinent information regarding patient needs must accompany the patient upon discharge from the inpatient setting, and must be included as part of the hospice medical record.

5. The medical record of a discharged patient must be completed within thirty days after discharge.

6. Records must be maintained by the agency for a period of not less than ten years following the date of discharge or death. In the case of a minor, the records must be maintained for a period of twelve years following the date of discharge or death.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-14. Patient and family rights.

1. Each hospice program must develop, adopt, implement, and make available for public review a statement of the rights and responsibilities of hospice patients and members of the hospice patient's family. This statement must be provided to the patient or family member designated by the patient, as evidenced by written acknowledgment, prior to or at

the time of admission to the hospice program. The statement must include, but is not limited to, provisions assuring each patient and family the following minimum rights:

a. The right to be clearly informed of the responsibilities of the hospice program for care of the patient and family, including services to be provided.

b. The right to be fully informed, at the time of admission, of the materials and equipment available to the patient and family, any existing prepayment, refund and sliding scale fee policies, estimated cost, and of patient and family financial responsibility.

c. The right to participate in the development of the hospice service plan.

d. The right to be informed by a physician of the patient's medical condition.

e. The right to privacy in treatment and in caring for personal needs, and confidentiality in the treatment of personal and medical records.

f. The right to be treated courteously, fairly, and with the fullest measure of dignity.

2. Each program must prepare a written plan to implement this subsection.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-15. Quality assurance. Each hospice program must conduct a comprehensive self-assessment of the quality and appropriateness of care provided to the patient and family in the home and inpatient services.

1. The governing body shall delegate in writing responsibilities for implementation and maintenance of a planned process for reviewing and evaluating the appropriateness of patient and family care, as well as resolving identified problems.

2. The goals, objectives, methods for implementation, and responsibilities for monitoring and evaluating for effectiveness and efficiency of patient and family care must be specified in a written quality assurance plan which is reevaluated at least annually.

3. The hospice program, through the quality assurance program, must implement and report on activities and mechanisms for monitoring

the quality of patient care, identify and resolve problems, and suggest improvements in patient care.

4. There must be documentation relating to the findings from and conclusions of the monitoring, evaluating, and problem solving activities, and the actions taken to resolve problems and improve patient and family services as defined in the quality assurance plan.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02

33-03-15-16. Utilization review.

1. The hospice program must appoint a utilization review committee whose responsibilities are to provide an ongoing evaluation and review of the hospice program and to make recommendations to the administrator who shall report findings and recommendations to the governing body on a timely basis. The committee shall meet at least semiannually and provide the administrator with dated, signed minutes of the meetings.

2. There must be a written utilization review plan describing the process used to monitor the utilization of the hospice program service and to resolve identified problems.

3. There must be evidence that the plan is reviewed at least annually and revised as necessary.

4. The utilization review committee shall conduct regular, ongoing utilization review to include, but not be limited to, a random sample and defined number of hospice medical records to determine at least the following:

   a. The appropriateness of admission to the hospice program.

   b. Continued stay longer than six months.

   c. If the hospice program service plan was directly related to the identified physical and social needs of the patient and family.

   d. If the service, medication, and treatment prescribed were in accordance with the current hospice service plan.

   e. If the hospice program of care appropriately utilized inpatient hospice care on a short-term basis only, and maintained itself primarily as a home care program.

5. In addition to the medical record review, the following sources of information may be obtained and reviewed:

a. Billing information.

b. Quality assurance findings.

c. Reimbursement.

6. When problems in the utilization of hospice program services are identified, there must be evidence that action is taken to correct the problems.

History: Effective July 1, 1987.
General Authority: NDCC 23-17.4, 28-32-02
Law Implemented: NDCC 23-17.4, 28-32-02